KANSAS DEPARTMENT ON AGING

LONG TERM CARE RESIDENT STATISTICS

Help

December 31, 2003

FACILITY NAME: _____
STREET ADDRESS: _____
CITY, STATE, ZIP: _____
LICENSURE TYPE: _____ STATE ID NUMBER: _____

Deadline for filing this report - January 9, 2004

This report shall be filed with the Licensure, Certification & Evaluation Commission (LCE), Ks. Dept. on Aging by Jan. 9, 2004. **All NURSING FACILITIES, ASSISTED LIVING FACILITIES, RESIDENTIAL HEALTH CARE FACILITIES, NURSING FACILITIES FOR MENTAL HEALTH AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED** are required to complete this report. Refer questions to Sandra Dickison, LCE, KDOA (785) 296-1245.

Section I. Resident Statistics

Help

A. Please record the number of residents in your facility on December 31, 2003 by age, group and sex.

NURSING FACILITIES

Current Resident Census	Total	Male	Female
1. Under 60	a.	b.	c.
2. 60-64	a.	b.	c.
3. 65-74	a.	b.	c.
4. 75-84	a.	b.	c.
5. 85 and Over	a.	b.	c.
6. ***TOTAL**	a.	b.	c.

ALF/RHCF

Current Resident Census	Total	Male	Female
1. Under 60	a.	b.	c.
2. 60-64	a.	b.	c.
3. 65-74	a.	b.	c.
4. 75-84	a.	b.	c.
5. 85 and Over	a.	b.	c.
6.***TOTAL**	a.	b.	c.

*This total MUST AGREE with the Resident Census on the last day of the reporting period (No. 10) of the Adult Care Home Semi-Annual Report.

B. Does your facility offer services to individuals other than residents? (e.g., Meals on Wheels, etc.)

Yes ❒ Specify _____ No ❒

C. Please record the number of residents in your facility on December 31, 2003 by source of INITIAL admission.

1.	Private Residence	_____	2.	Boarding Home	_____
3.	Retirement Apts	_____	4.	Assisted Living	_____
5.	Nursing Facility	_____	6.	Residential Hlth Care	_____
7.	General Hospital	_____	8.	Psychiatric Hospital	_____
9.	Veterans Hospital	_____	10.	All other	_____

11. *TOTAL (1-10) _____

D. Please record the number of residents in your facility on December 31, 2003 by primary source of payment.

1.	Medicare	_____	2.	Medicaid	_____
3.	Private Pay	_____	4.	Commercial Ins.	_____
5.	V.A. Benefits	_____	6.	All Other	_____

7. *TOTAL (1-6) _____

Section II. Please record the number of residents in your facility on the last day of the year by county of residence at the time of **INITIAL** admission.

Allen		Finney		Logan		Rooks	
Anderson		Ford		Lyon		Rush	
Atchison		Franklin		Marion		Russell	
Barber		Geary		Marshall		Saline	
Barton		Gove		McPherson		Scott	
Bourbon		Graham		Meade		Sedgwick	
Brown		Grant		Miami		Seward	
Butler		Gray		Mitchell		Shawnee	
Chase		Greeley		Montgomery		Sheridan	
Chautauqua		Greenwood		Morris		Sherman	
Cherokee		Hamilton		Morton		Smith	
Cheyenne		Harper		Nemaha		Stafford	
Clark		Harvey		Neosho		Stanton	
Clay		Haskell		Ness		Stevens	
Cloud		Hodgeman		Norton		Sumner	
Coffey		Jackson		Osage		Thomas	
Comanche		Jefferson		Osborne		Trego	
Cowley		Jewell		Ottawa		Wabaunsee	
Crawford		Johnson		Pawnee		Wallace	
Decatur		Kearny		Phillips		Washington	
Dickinson		Kingman		Pottawatomie		Wichita	
Doniphan		Kiowa		Pratt		Wilson	
Douglas		Labette		Rawlins		Woodson	
Edwards		Lane		Reno		Wyandotte	
Elk		Leavenworth		Republic		Out-of-State	
Ellis		Lincoln		Rice		***TOTAL**	
Ellsworth		Linn		Riley			

***This total must agree with No. 10 on the semi-annual report).**

Signature of Administrator/Operator (Administrator's License No.) Date (DD/MM/YYYY) E Mail Address Phone No.

******* RETURN TO: LCE/KDOA, 1000 SW JACKSON, SUITE 330, TOPEKA, KS 66612-1365 *******

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